NOLAND LAW FIRM, LLC

Confidential Medical Negligence Questionnaire

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Noland Law Firm, LLC
-2010-

INSTRUCTIONS

Please answer the following questions as fully and accurately as possible. A full and complete disclosure is critical. The following information will be needed in order to properly advise you and handle your case. Please print and fill out every applicable question. If a question is not applicable, please write N/A in the space. Do not leave blanks. This information will help us help you. This information will be kept confidential.

If you need more space, please attach another sheet and clearly indicate which question you are answering. If you are not certain about an answer, leave the space blank. If any question is not applicable, write "N/A" in the blank. You may wish to make a copy to retain for your own records.

You need to keep attorney advised as to your current address and phone number(s).

Any of the information provided to us by you in this questionnaire will be held in the strictest confidence by the Noland Law Firm, LLC.

MEDICAL NEGLIGENCE QUESTIONNAIRE

DATE:_____

BACKGROUND:

FULL NAME: _____

ADDRESS: _____ CITY_____ STATE: _____ ZIP_____

PHONE: (H) _____ (W) _____ OTHER _____

CELL:_____ EMAIL:_____

SSN: _____ DOB: _____

EDUCATION: _____

MARITAL STATUS: (M) (S) (D) _____

PRIOR MARRIAGES, IF SO LIST:_____

SPOUSE'S BACKGROUND:

FULL NAME: _____

ADDRESS: _____ CITY_____ STATE: _____ ZIP_____

PHONE: (H) _____ (W) _____ OTHER _____

CELL:_____ EMAIL:_____

SSN: _____ DOB: _____

EDUCATION: _____

PERSON WHO WILL ALWAYS KNOW YOUR WHEREABOUTS:

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____ CITY_____ STATE: _____ ZIP_____

PHONE: (H) _____ (W) _____ OTHER _____

WHO REFERRED YOU TO OUR OFFICE?_____

CHILDREN:

PLEASE FURNISH FULL NAME, ADDRESS, BIRTH DATE AND AGE OF ALL CHILDREN:

FULL NAME:_____

PRESENT ADDRESS:_____

DATE OF BIRTH:_____

AGE:_____

FULL NAME:_____

PRESENT ADDRESS:_____

DATE OF BIRTH:_____

AGE:_____

FULL NAME:_____

PRESENT ADDRESS:_____

DATE OF BIRTH:_____

AGE:_____

EMPLOYMENT INFORMATION:

EMPLOYER: _____

ADDRESS: _____ CITY _____ STATE _____ ZIP _____

TELEPHONE:_____ DATE OF HIRE: _____ LENGTH EMPLOYED:_____

JOB DUTIES:_____

RATE OF PAY: (SALARY) _____ (HRLY RATE)_____

(HRS PER DAY) _____ (DAYS PER WEEK) _____

(OVERTIME RATE) _____ (OVERTIME HOURS) _____

(FRINGE BENEFITS) _____

(PART TIME) _____

LOST WAGES:

LOST TIME FROM WORK, RATE OF PAY AND, ESTIMATED LOST WAGES AND EXPLAIN HOW YOU HAVE CALCULATED THE SAME:_____

_____

LOSS OF BUSINESS PROFITS OR LOSS OF INCOME FROM OTHER SOURCES:

_____

ARE YOU OR HAVE YOU RECEIVED DISABILITY BENEFITS AS A RESULT OF THIS ILLNESS OR INJURY? IF YES, PLEASE DESCRIBE:_____

_____

HEALTH INSURANCE INFORMATION:

THE NAME OF YOUR PRIMARY/PRIVATE HEALTH INSURANCE CARRIER AND THE GROUP OR POLICY NUMBER OF SAME. _____

OTHER ASSISTANCE:

ARE YOU A MEDICAID RECIPIENT? IF YES, PLEASE PROVIDE YOUR MEDICAID NUMBER. _____

ARE YOU A MEDICARE RECIPIENT? IF YES, PLEASE PROVIDE YOUR MEDICARE NUMBER. _____

DO YOU RECEIVE SOCIAL SECURITY BENEFITS? IF SO, PLEASE STATE MONTHLY AMOUNT_____

WERE MEDICARE OR MEDICAID BENEFITS PAID IN ASSOCIATION WITH THE BELOW LISTED MEDICAL TREATMENT? YES _____ NO _____

INFORMATION REGARDING INCIDENT:

IDENTIFY ALL HEALTH CARE PROVIDERS YOU BELIEVE CAUSED YOUR INJURY.

_____

_____

_____

THE CONDITION FOR WHICH YOU WERE BEING TREATED: _____

_____

_____

_____

DESCRIBE IN DETAIL HOW AND WHY YOU BELIEVE THE INCIDENT OCCURRED. INCLUDE IN YOUR RESPONSE THE SOURCE OF THIS INFORMATION OR BELIEF.

_____

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LIST THE NAME AND ADDRESS OF ALL HEALTH CARE PROVIDERS (DOCTORS, NURSES, HOSPITALS, TECHNICIANS, OR OTHER HOSPITAL OR MEDICAL PERSONNEL) WHO WERE INVOLVED IN THE INCIDENT. _____

_____

_____

_____

_____

_____

_____

_____

WERE YOU REFERRED TO THESE HEALTH CARE PROVIDERS BY ANYONE?

YES _____ NO _____

IF SO, BY WHOM? _____

_____

_____

LIST THE NAME AND ADDRESS OF ALL DOCTORS, NURSES, TECHNICIANS, OR OTHER MEDICAL OR HOSPITAL PERSONNEL WHO EXAMINED YOU, INTERVIEWED YOU, OR CAME INTO CONTACT WITH YOU BEFORE THE INCIDENT. _____

_____

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_____

DID YOU HAVE ANY PREVIOUS CONTACT WITH ANY OF THE SAME DOCTORS, NURSES, TECHNICIANS, MEDICAL OR HOSPITAL PERSONNEL BEFORE THE DAY THE INCIDENT OCCURRED? YES _____ NO _____

IF SO, GIVE DETAILS _____

_____

_____

_____

WERE YOU ASKED TO SIGN ANY WAIVER FORMS, IMPLIED CONSENT FORMS, OR OTHER DOCUMENTS BEFORE OR AFTER THE INCIDENT?

YES _____ NO _____

IF SO, DID YOU SIGN? YES _____ NO _____

DO YOU HAVE A COPY OF THE DOCUMENT? YES _____ NO _____

WERE ANY OF THE PERSONS INVOLVED YOUR REGULAR TREATING PHYSICIAN?

YES _____ NO _____

IF SO, GIVE HIS/HER NAME AND ADDRESS. _____

_____

_____

_____

LIST THE NAME AND ADDRESS OF ALL DOCTORS, NURSES, TECHNICIANS, MEDICAL OR OTHER HOSPITAL PERSONNEL WHO CAME IN CONTACT WITH YOU OR TREATED YOU AFTER THE INCIDENT. _____

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DID YOU GIVE A HISTORY TO ANYONE?

YES _____ NO _____

IF SO, TO WHOM? _____

_____

IF YOU YOURSELF DID NOT GIVE A HISTORY, DID ANYONE GIVE A HISTORY ON YOUR BEHALF? YES _____ NO _____

IF SO, WHO GAVE THE HISTORY? _____

_____

TO WHOM? _____

_____

HAVE YOU RECEIVED ANY DOCUMENTS FROM THE HEALTH CARE PROVIDERS, THEIR INSURANCE CARRIERS, OR THEIR ADJUSTERS CONCERNING THE INCIDENT? YES _____ NO _____

IF SO, DO YOU HAVE COPIES? YES _____ NO _____

DID YOU GIVE ANY STATEMENTS TO ANYONE CONCERNING THE INCIDENT?

YES _____ NO _____

IF SO, TO WHOM DID YOU GIVE THE STATEMENT, WHERE AND WHEN DID YOU GIVE THE STATEMENT AND DO YOU HAVE A COPY? _____

_____

_____

_____

_____

LIST THE NAMES AND ADDRESSES OF ALL WITNESSES TO THE INCIDENT. INCLUDE ANY PERSONS WHO ACCOMPANIED YOU TO THE HOSPITAL OR DOCTOR'S OFFICE. _____

_____

_____

_____

_____

HAVE YOU SPOKEN TO ANY OF THE DEFENDANTS, THEIR AGENTS, OR TO ANY OTHER PERSON ABOUT THE INCIDENT? YES _____ NO _____

IF SO, GIVE DETAILS. _____

_____

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_____

WERE ANY PHOTOGRAPHS, PICTURES OR FILMS TAKEN OF YOU AFTER THE INCIDENT? YES _____ NO _____

IF SO, WHO TOOK THEM, WHEN, AND WHERE? _____

_____

_____

_____

DO YOU HAVE A COPY? YES _____ NO _____

WERE YOU BEING TREATED AT THE TIME OF THE INCIDENT FOR A CONDITION OR INJURY WHICH YOU SUSTAINED IN THE COURSE OF YOUR EMPLOYMENT?
YES _____ NO _____

HAS ANY OTHER HEALTH CARE PROVIDER EVER TOLD YOU THAT MALPRACTICE WAS COMMITTED? YES _____ NO _____

IF SO, IDENTIFY THE HEALTH CARE PROVIDER. _____

_____

_____

PROVIDE THE DATE THAT YOU WERE FIRST GIVEN THIS KNOWLEDGE. _____

_____

_____

WHAT DID THE HEALTH CARE PROVIDER TELL YOU? _____

_____

_____

_____

_____

_____

MEDICAL TREATMENT:

PLEASE LIST BELOW THE MEDICAL CARE PROVIDERS INVOLVED IN THE ABOVE INCIDENT/OCCURRENCE. ATTACH A SEPARATE SHEET IF NECESSARY.

HOSPITALS	TREATMENT	DATES OF SERVICES

DOCTORS	TREATMENT	DATES OF SERVICES

PHYSICAL THERAPY	TREATMENT	DATES OF SERVICES

PHARMACIES	**PRESCRIPTIONS**	**DATES OF SERVICES**

MEDICAL DEVICES	**PRESCRIBED BY**	**PERMANENT/TEMP.**

PRESENT COMPLAINTS

_____

_____

_____

_____

_____

PRIOR ACCIDENT(S) (TO INCLUDE: car accidents, slip and falls, and any other accidents in which you received injuries)

DATE	LOCATION / DESCRIBE
_____	_____
_____	_____
_____	_____
_____	_____

PRIOR INJURIES (TO INCLUDE: All vehicular injuries, falls, military, sport)

DATE	DESCRIPTION/TREATMENT
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PRIOR HOSPITALIZATIONS: (TO INCLUDE: every time you have been hospitalized in the last 20 years)

DATE	REASON	HOSPITAL / DOCTOR(S)
_____	_____	_____
_____	_____	_____
_____	_____	_____

OTHER INFORMATION:

HAVE YOU EVER BEEN ARRESTED OR CONVICTED OF A CRIMINAL OFFENSE?

FELONY: YES ____ NO ____ MISDEMEANOR: YES ___ NO ____

IF YES, LIST: OFFENSE, DATE & JURISDICTION _____

_____

HAVE YOU EVER BEEN A PARTY IN ANY PREVIOUS LAWSUITS OR MADE A CLAIM FOR PERSONAL INJURY? IF SO, PLEASE DESCRIBE IN DETAIL:

_____

_____

HAVE YOU KEPT ANY DIARIES OR CALENDARS OF EVENTS ASSOCIATED WITH THIS ILLNESS OR INJURY? IF YES, PLEASE IDENTIFY:_____

_____

HAVE YOU EVER FILED FOR BANKRUPTCY? YES ___ NO ____

IF SO, WHEN?

ARE YOU PLANNING OR CONSIDERING FILING FOR BANKRUPTCY IN THE NEXT 6 MONTHS? YES ___ NO ____

YOU MUST NOTIFY YOUR ATTORNEY IF YOU ARE CONSIDERING OR IF YOU OR YOUR SPOUSE FILE FOR BANKRUPTCY.

ANY OTHER INFORMATION YOU FEEL IMPORTANT AND WOULD LIKE TO PROVIDE:

_____

_____

_____

_____

_____

_____

DATE: _____ _____

CLIENT

THIS INFORMATION IS CONFIDENTIAL AND ONLY FOR THE USE OF NOLAND LAW FIRM, LLC.

End of questionnaire

CONFIDENTIAL